

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09566

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARINERS SECTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last BEDSWORTH		4. DATE OF DEATH Month August Day 27 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 8 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY RETAIL GROCERY	
11. BIRTHPLACE (State or foreign country) CRISFIELD, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME CHARLES BEDSWORTH		14. MOTHER'S MAIDEN NAME CORNELIA WARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 220-32-0940	
17. INFORMANT MRS. NELL BEDSWORTH-- Address CRISFIELD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Bronchopneumonia DUE TO Bronchogenic Carcinoma (c) 6 weeks		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 days 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14 19 60 , to 8/27 19 60 , that (I) (we) last saw the deceased alive on 8/26 19 60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE A. N. Barr, M.D.		22b. DATE SIGNED 8/27/60	
22c. PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		22d. ADDRESS MAIN ST.-- CRISFIELD, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 29, 1960	
23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY		23d. LOCATION (City, town, or county) (State) CRISFIELD, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		25a. REC'D BY REGISTRAR SEP 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Knead			

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STATE OF TEXAS

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CHIEF OF POLICE

FOR CUSTODY

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CERTIFICATE OF DEATH

09567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>I20 W, South Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Cottman</u> Last <u>Cottman</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/6/1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	IF UNDER 24 HRS. Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Samuel Cottman</u>		14. MOTHER'S MAIDEN NAME <u>Julia Tilghman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth Cottman, Princess Anne, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>443X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Serility</u> DUE TO (c) <u>Serility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension + Secondary Anemia</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs.</u> <u>15 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1958</u> to <u>Aug. 2, 1960</u> , that I last saw the deceased alive on <u>Aug. 2, 1960</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Lewis</u>		DATE SIGNED <u>Princess Anne, Md. 8-4-60</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Lewis, M.D.</u>		<u>Princess Anne, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr</u>		ADDRESS <u>Princess Anne, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. HENRY		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
100 N. BOSTON ST.		JAN 10 1900		HIS HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		TENDENCY TO DISEASE	
CLOCK REPAIRER		8 YEARS		MARRIED		NONE		NONE	
BIRTH		DATE OF BIRTH		PLACE OF BIRTH		PARENTS		MOTHER	
JAN 10 1855		JAN 10 1855		MASSACHUSETTS		JAMES J. HENRY		MARY J. HENRY	
FATHER		MOTHER		SISTER		BROTHER		CHILDREN	
JAMES J. HENRY		MARY J. HENRY		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
J. J. HENRY		M. J. HENRY		J. J. HENRY		J. J. HENRY		J. J. HENRY	
DATE		TIME		PLACE		CAUSE		MANNER	
JAN 10 1900		10:00 AM		HIS HOME		HEART DISEASE		NATURAL	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9602

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Chautauqua</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rumbley,</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dunkirk</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Aggebrecht</u> Last <u>Aggebrecht</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21,</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1869</u>		9. AGE (In years last birthday) <u>91 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Dunkirk, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Miers</u>				14. MOTHER'S MAIDEN NAME <u>Marie Tate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>W. F. Eggebrecht, Rumbley, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/22/60</u>			
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fredonia, New York</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Throckmorton</u>	

MEDICAL CERTIFICATION

105204

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8803

1. Name of Deceased: _____

2. Sex: _____ Age: _____

3. Date of Death: _____

4. Place of Death: _____

5. Cause of Death: _____

6. Manner of Death: _____

7. Signature of Medical Examiner: _____

8. Date of Signature: _____

9. Signature of Coroner: _____

10. Date of Signature: _____

11. Signature of Registrar: _____

12. Date of Signature: _____

13. Signature of Burial Officer: _____

14. Date of Signature: _____

15. Signature of Undertaker: _____

16. Date of Signature: _____

17. Signature of Funeral Home: _____

18. Date of Signature: _____

19. Signature of Cemetery: _____

20. Date of Signature: _____

21. Signature of Burial: _____

22. Date of Signature: _____

23. Signature of Interment: _____

24. Date of Signature: _____

25. Signature of Burial: _____

26. Date of Signature: _____

27. Signature of Interment: _____

28. Date of Signature: _____

29. Signature of Burial: _____

30. Date of Signature: _____

31. Signature of Interment: _____

32. Date of Signature: _____

33. Signature of Burial: _____

34. Date of Signature: _____

35. Signature of Interment: _____

36. Date of Signature: _____

37. Signature of Burial: _____

38. Date of Signature: _____

39. Signature of Interment: _____

40. Date of Signature: _____

41. Signature of Burial: _____

42. Date of Signature: _____

43. Signature of Interment: _____

44. Date of Signature: _____

45. Signature of Burial: _____

46. Date of Signature: _____

47. Signature of Interment: _____

48. Date of Signature: _____

49. Signature of Burial: _____

50. Date of Signature: _____

51. Signature of Interment: _____

52. Date of Signature: _____

53. Signature of Burial: _____

54. Date of Signature: _____

55. Signature of Interment: _____

56. Date of Signature: _____

57. Signature of Burial: _____

58. Date of Signature: _____

59. Signature of Interment: _____

60. Date of Signature: _____

61. Signature of Burial: _____

62. Date of Signature: _____

63. Signature of Interment: _____

64. Date of Signature: _____

65. Signature of Burial: _____

66. Date of Signature: _____

67. Signature of Interment: _____

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69. Signature of Burial: _____

70. Date of Signature: _____

71. Signature of Interment: _____

72. Date of Signature: _____

73. Signature of Burial: _____

74. Date of Signature: _____

75. Signature of Interment: _____

76. Date of Signature: _____

77. Signature of Burial: _____

78. Date of Signature: _____

79. Signature of Interment: _____

80. Date of Signature: _____

81. Signature of Burial: _____

82. Date of Signature: _____

83. Signature of Interment: _____

84. Date of Signature: _____

85. Signature of Burial: _____

86. Date of Signature: _____

87. Signature of Interment: _____

88. Date of Signature: _____

89. Signature of Burial: _____

90. Date of Signature: _____

91. Signature of Interment: _____

92. Date of Signature: _____

93. Signature of Burial: _____

94. Date of Signature: _____

95. Signature of Interment: _____

96. Date of Signature: _____

97. Signature of Burial: _____

98. Date of Signature: _____

99. Signature of Interment: _____

100. Date of Signature: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>		c. LENGTH OF STAY IN 1b <u>hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chance</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u></u> Last <u>Handy</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> , Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1916</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. UNDER 1 YEAR Months <u></u> Days <u></u>		11. UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer & Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Tyaskin, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Handy - Chance, Maryland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Neudie Handy - Chance, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Myocarditis</u> (a), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/30/60</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Handy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newtown, Wicomico Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Webster Deal</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

100

CERTIFICATE OF DEATH

09571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RHODES POINT	
c. LENGTH OF STAY IN 1b 1 DAY		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle LOUIS Last HOFFMAN		4. DATE OF DEATH Month AUGUST Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-10-1881
9. AGE (in years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GRIFFITH HOFFMAN		14. MOTHER'S MAIDEN NAME ANNA EVANS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-03-1479	
17. INFORMANT MARY A. BRADSHAW		Address MYRTLE ST., CRISFIELD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Passive Congestion 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation Fracture of left hip (one day)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20 , 19 54 , to 8-15 , 19 60 , that I last saw the deceased alive on AUG. 15 , 19 60 , and that death occurred at 11:55AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. P. Barr		ADDRESS (Street, city or town, state) MAIN STREET	
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		DATE SIGNED 8/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Aug. 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rhodes Point Cemetery		22d. LOCATION (City, town, or county) (State) Rhodes Point, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR AUG 19 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9601

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09572

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne - Rural Route 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Holbrook Last Holbrook				4. DATE OF DEATH Month August Day 14 , Year 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/1913	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 14		IF UNDER 24 HRS. Hours 14 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert Stevenson				14. MOTHER'S MAIDEN NAME Elizabeth Curtis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Charles Edward Holbrook - Rt.2-Princess Anne, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma with generalized osteoporosis 203X DUE TO (b) Metastasis to the lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 18 months at least.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-18-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. (Polks Road)	
						22d. LOCATION (City, town, or county) (State) Pr. Anne, Somerset Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Johnson				24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

20

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



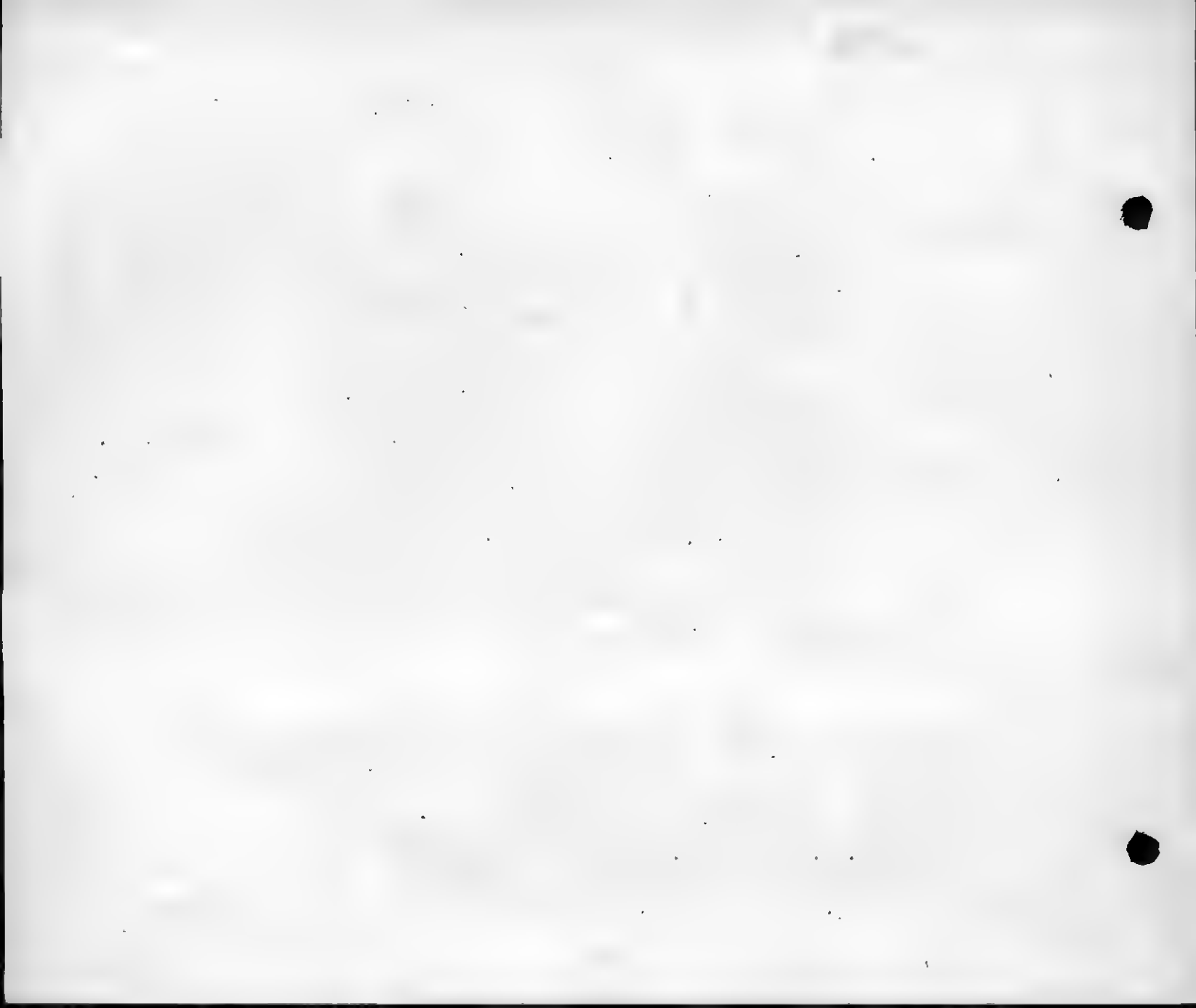
9596

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09573

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mariner's Section				d. STREET ADDRESS 1 Mariner's Section			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MYRTLE		Middle MARIAN		Last JOHNSON	
4. DATE OF DEATH		Month August		Day 8		Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1889		9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Somers				14. MOTHER'S MAIDEN NAME Ocie Anna Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Pauline Johnson, Mariners, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Serious chronic arterial hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis - 7 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1960 to Aug 8, 1960 , that (I) (we) last saw the deceased alive on July 7, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. N. BARR, M. D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/14/60			
22c. PHYSICIAN'S NAME (Type) A. N. BARR, M. D.		22d. ADDRESS CRISFIELD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 19 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kious			

TO HOSPITAL OR ATTENDING PHYSICIAN The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

9597

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>2911-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Evans</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Evans</u>				14. MOTHER'S MAIDEN NAME <u>Addie Holland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yet, give war or dates of service)		17. INFORMANT <u>Evelyn Byrd - Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/11/60</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Meth. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Crisfield Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9606

CERTIFICATE OF DEATH

09575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Marion Station		c. LENGTH OF STAY IN 1b minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Colbourne's Creek		d. STREET ADDRESS 704 Market Street	
3. NAME OF DECEASED (Type or print) First STEPHEN Middle MASON Last PAYNE		4. DATE OF DEATH Month August Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1885
9. AGE (In years last birthday) yrs 75		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses Payne		14. MOTHER'S MAIDEN NAME Ellen Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-26-4783	
17. INFORMANT Mrs Walter P. Mitchell, Pocomoke City, Md		Address 704 Market St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis of Coronary Arteries DUE TO (c) Ventricular Fibrillation INTERVAL BETWEEN ONSET AND DEATH Very Brief			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Ventricular Hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Pocomoke Worcester Md.	
21. I certify that I attended the deceased from April 1960 to 13 August 1960 that I last saw the deceased alive on 12 August 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE N. E. Sartorius, Jr. M.D.			
PHYSICIAN'S NAME (Type) N. E. Sartorius, Jr., M.D., 114 Market St., Pocomoke City, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-60	
22c. NAME OF CEMETERY Remson Methodist		22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9607

CERTIFICATE OF DEATH

09576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		2. USUAL RESIDENCE (Where deceased lived If institution Res'dence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Princess Anne		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arinthia V. Pritchett		4. DATE OF DEATH August 2 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1887
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James MacLane		14. MOTHER'S MAIDEN NAME Emma Maddox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT Mrs. Emily Nikkinen, Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-11-56 , 19 60 , to Aug 2 , 19 60 , that I last saw the deceased alive on Aug 2 , 19 60 , and that death occurred at 9p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Everett C. Sutter M.D.		Princess Anne, Maryland	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Aug. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY Grace Episcopal	22d. LOCATION (City, town, or county) (State) Mt. Vernon, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James L. ...		24a. REC'D BY REGISTRAR Aug 5 '60	24b. REGISTRAR'S SIGNATURE ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

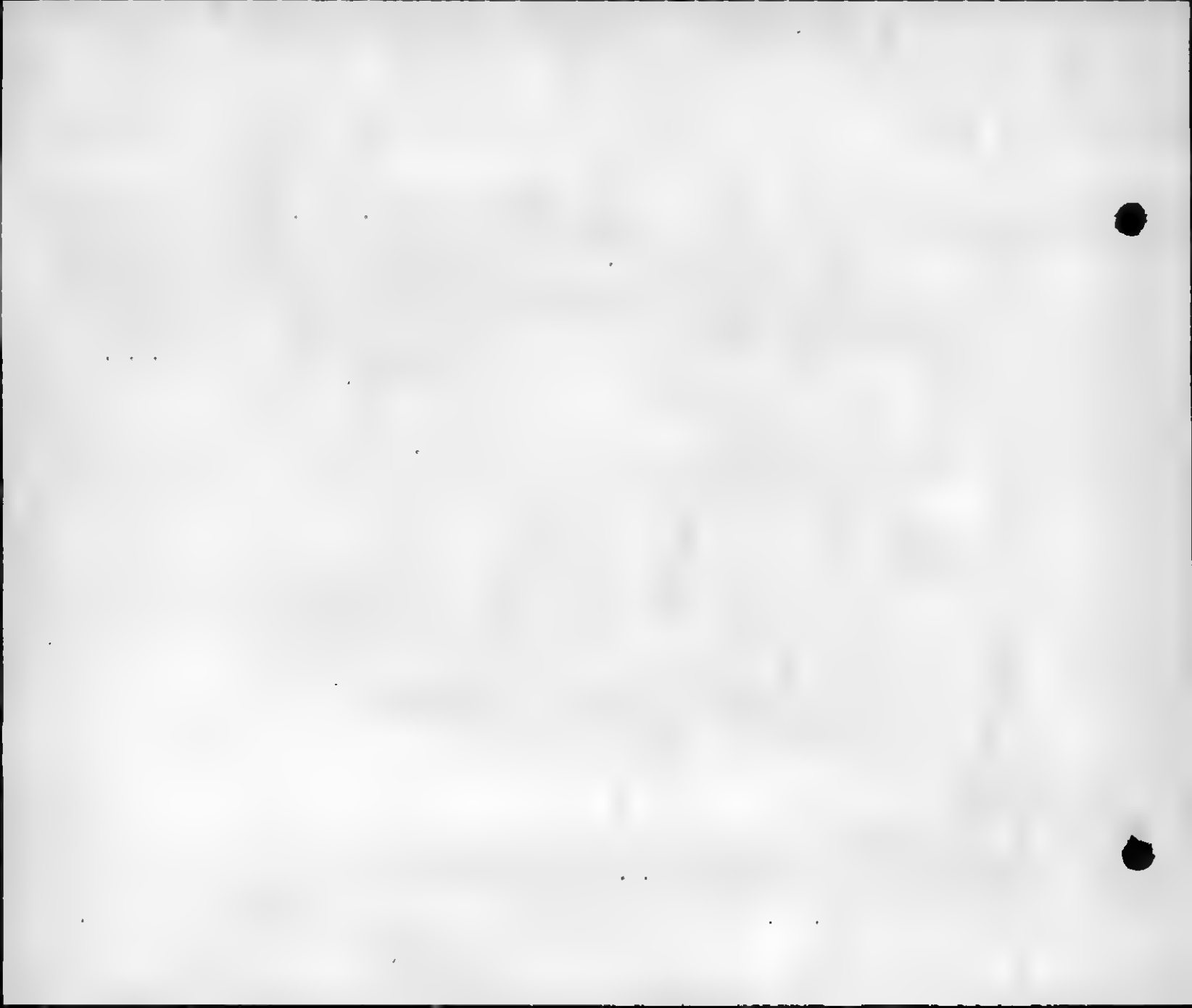
VS. A15ME(S)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> <u>7-3-X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>141 N. 58th. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>L.</u> Last <u>Scriber</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Scriber</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Mrs. Hattie Tourney</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cebro-Vascular Accident</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 Min.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Robert H. Johnson</u> EXAMINER'S NAME (Type) <u>Robert H. Johnson M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawsonia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons</u> ADDRESS <u>Crisfield, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9608

CERTIFICATE OF DEATH

09578
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edw. W. McCready Memorial Hosp.		d. STREET ADDRESS 49 Ashbury Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elwood C Sterling		4. DATE OF DEATH Month Day Year August 7 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Sterling		14. MOTHER'S MAIDEN NAME Rebecca ANNIE STERLING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Meta Sterling Address Crisfield, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Acute - Fulminating Hepatitis - DUE TO 7. Carcinomatous (Carcinoma of Hepatic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding ulcer (Gastric Hemorrhage)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1960, to Aug. 7, 1960, that I last saw the deceased alive on August 7, 1960, and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sarah M. Peyton, M.D. Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ashbury Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
ADDRESS Crisfield, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



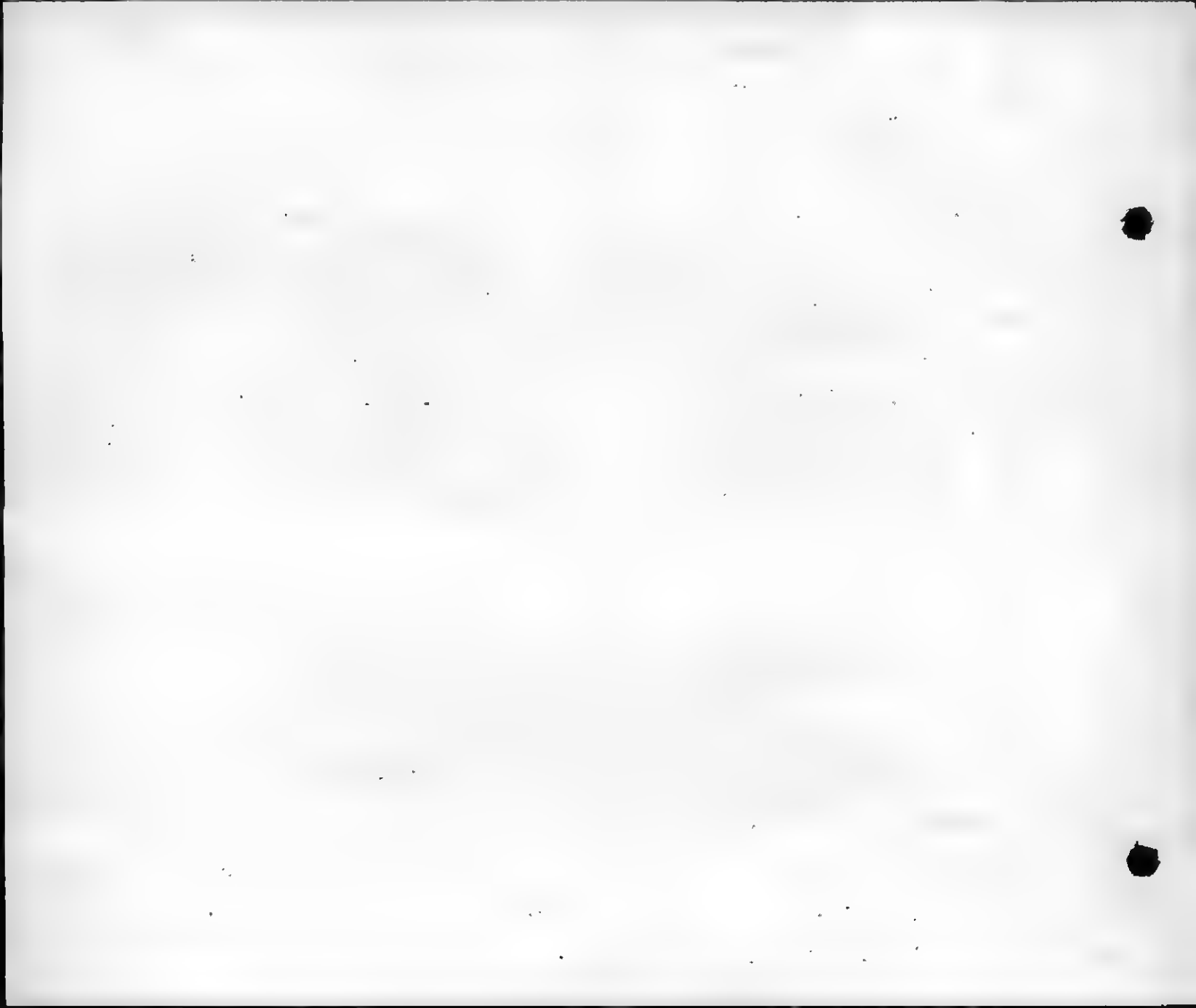
9609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 27 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. McCREADY MEMORIAL HOSPITAL				d. STREET ADDRESS 122 HALL HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOYD Middle JAMES Last STERLING		4. DATE OF DEATH Month AUGUST Day 2ND Year 19 60		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 11, 1886		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD		10b. KIND OF BUSINESS OR INDUSTRY Dealer & Packer		11. BIRTHPLACE (State or foreign country) CRISFIELD, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. JEROME STERLING				14. MOTHER'S MAIDEN NAME LAVENIA STERLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address CRISFIELD ANNIE STERLING 122 HALL HIGHWAY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 2 hrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple rib fractures (Post accident)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from JULY 7TH, 1960 to AUG 2 , 1960 that I last saw the deceased alive on AUGUST 2, 1960 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE C.G. Rawley		M.D. C.G. RAWLEY, M.D.		CRISFIELD, MARYLAND			
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	
22d. LOCATION (City, town, or county) (State) Crisfield, Md.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Henshaw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9599

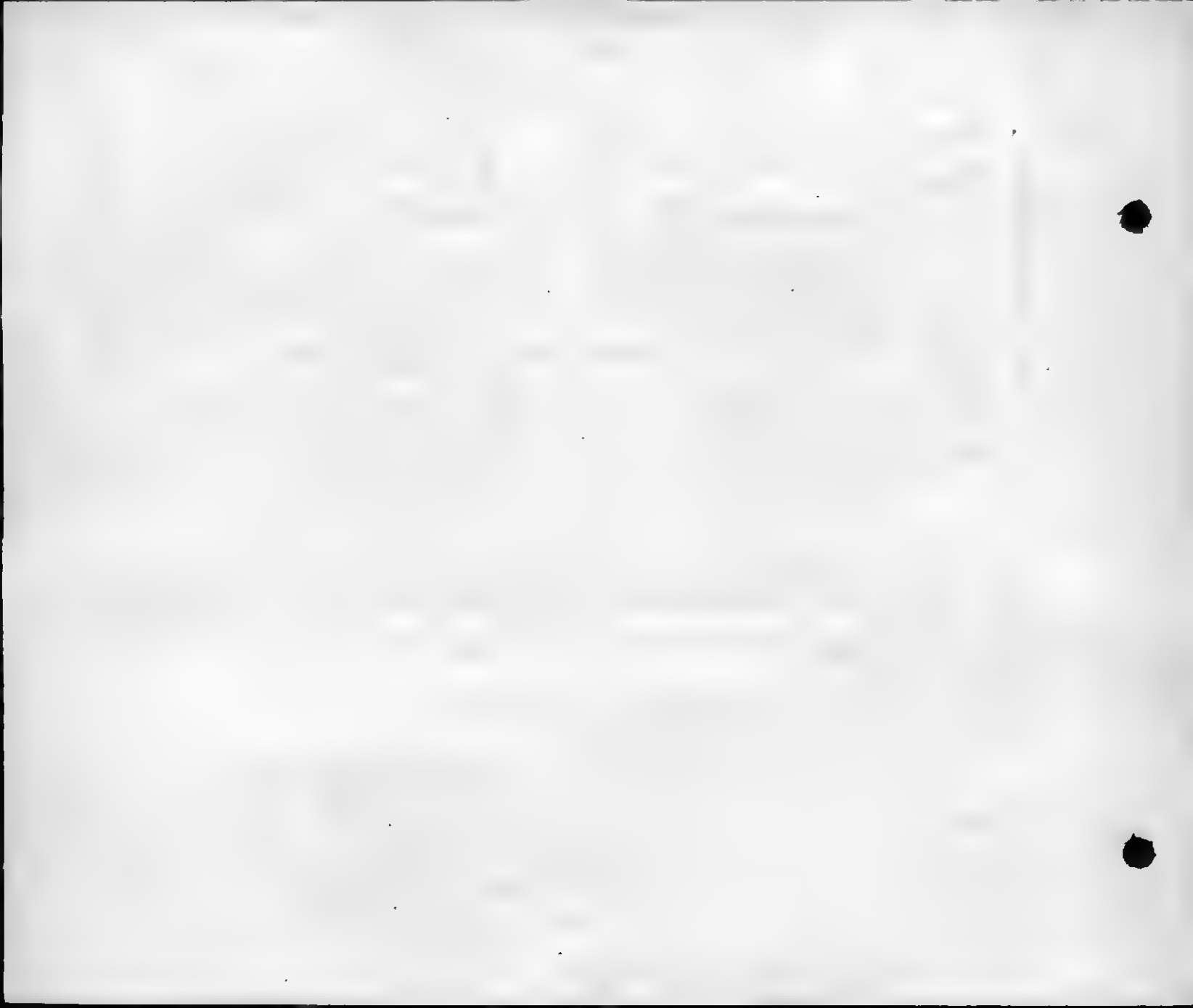
CERTIFICATE OF DEATH

09580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY SOMERSET MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HIS HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WESLEY WARD		4. DATE OF DEATH Month Day Year AUG- 8 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 19- 1895
9. AGE (In years lost birthdate yrs) 65		IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) MERETAN SEAFOOD PACKER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ZACK WARD		14. MOTHER'S MAIDEN NAME MINNIE WARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 219-14-850	
17. INFORMANT DOUGLAS WARD - CRISFIELD MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 8, 1960 to Aug 8, 1960 , that I last saw the deceased alive on Aug 8, 1960 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sarah M. Peyton MD 332 W. Main - Crisfield Md Aug 10			
ACTUAL SIGNATURE Sarah M. Peyton			
PHYSICIAN'S NAME (Type) Sarah M. Peyton			
22a. BURIAL, CREMATION, or other disposal (Specify) BURIED Aug 11 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY SUNNY RIDGE		22d. LOCATION (City, town, or county) (State) HOPEWELL MD	
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Webster		24a. REC'D BY REGISTRAR DATE AUG 22 '60	
ADDRESS Chesfield		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VS A15 (4)
JSM 10/57



9610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edw. W. McCready Memo. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle A. Last WARD		4. DATE OF DEATH Month August Day 6 Year 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, '76
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Parker Barnes		14. MOTHER'S MAIDEN NAME Maryella Lankford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
INFORMANT Edw. Ward		Address Westover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 904.0 DUE TO Face First Left Femur, neck (Aug 23 fall) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Clonus Int. rupture Clonus myoclonus DUE TO General Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arterio Sclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at her home	
20c. TIME OF INJURY Month, Day, Year Hour 2 m. July 23 1960 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Her home		20f. (City or town) (County) (State) Som.	
21. I certify that I attended the deceased from July 23, 1960 , to Aug 6, 1960 , that I last saw the deceased alive on Aug 6, 1960 , and that death occurred at 3:10 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Coulbourn M.D.		DATE SIGNED Marion, Maryland	
PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.		Marion, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rehobeth Presbyterian		22d. LOCATION (City, town, or county) (State) Rehobeth Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons		ADDRESS Crisfield, Md.	
24a. REC'D BY REGISTRAR AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

(M)

0010

STATE OF TEXAS

County of _____

City of _____

1900

Know all men by these presents, that _____

of the County of _____ State of Texas

do hereby certify that _____

is the true and correct copy of the _____

as the same appears from the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

and the _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9611

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b <u>Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marion Station</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Garfield</u> Middle <u>Young</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion Station</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Jackson Young</u>		14. MOTHER'S MAIDEN NAME <u>Amandy Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>David Young</u>		Address <u>Marion St., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Sclerotic Heart Disease</u> 444X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 15 - 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Aug. 17 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Marion Station</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hall - Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Knud</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and signature.

[Faint, mostly illegible handwritten text is visible throughout the form.]